



Service Requisition Form

Referring Physician: _____

Phone _____ Fax: _____

Patient Name: _____

Phone _____ Date of Birth: _____

MD Signature Required: _____

3201 South Austin Ave.
Suite 255
Georgetown, TX 78626
ph 512.501.4287
toll free 866.703.6681
fax 866.591.1084

930 Kohlers Crossing
Ste. 650
Kyle, TX 78640
ph 512.651.8420
toll free 866.746.1378
fax 866.591.1084

www.ctvstexas.com

Referral for Office Consultation

Cardiothoracic

- | | | |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Stephen J. Dewan, M.D. | <input type="checkbox"/> Eric M. Hoenicke, M.D. | <input type="checkbox"/> Robert C. Neely, M.D. |
| <input type="checkbox"/> Mark C. Felger, M.D. | <input type="checkbox"/> Brannon R. Hyde, M.D. | <input type="checkbox"/> Brendan P. Dewan, M.D. |
| <input type="checkbox"/> William F. Kessler, M.D. | <input type="checkbox"/> W. Chance Conner, M.D. | <input type="checkbox"/> First Available |
| <input type="checkbox"/> Hunter Q. Kirkland, M.D. | <input type="checkbox"/> Jonathan A. Yang, M.D. | |
| <input type="checkbox"/> Faraz Kerendi, M.D. | <input type="checkbox"/> Jeffrey D. McNeil, M.D. | |

Surgical Evaluation for:

- | | | |
|--------------------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Ascending Aortic Aneurysm | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Mitral Valve Disease | <input type="checkbox"/> Aortic Valve Disease | <input type="checkbox"/> Other _____ |

Thoracic/Pulmonary Rachel L. Medbery, M.D. Matthew A. Gaudet, M.D. First Available

Reason for Referral:

- | | | |
|---------------------------------------------|----------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Lung Nodule/Biopsy | <input type="checkbox"/> Mediastinal Mass | <input type="checkbox"/> Diaphragm Paralysis |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Chest Wall Deformity/Pectus |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Dysphasia/Achalasia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hyperhidrosis | <input type="checkbox"/> Esophageal Cancer | |

Vascular

- | | | |
|--------------------------------------------------|-------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Phillip J. Church, M.D. | <input type="checkbox"/> Scott A. Seidel, M.D. | <input type="checkbox"/> Ryan S. Turley, M.D. |
| <input type="checkbox"/> John K. Politz, M.D. | <input type="checkbox"/> Jeffrey M. Apple, M.D. | <input type="checkbox"/> Taylor A. Smith, M.D. |
| <input type="checkbox"/> Stephen M. Settle, M.D. | <input type="checkbox"/> Bradley A. Boone, M.D. | <input type="checkbox"/> Nicolas Zea, M.D. |
| <input type="checkbox"/> Joe K. Wells, M.D. | <input type="checkbox"/> David A. Nation, M.D. | <input type="checkbox"/> First Available |

Reason for Referral:

- | | | |
|------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Carotid Stenosis | <input type="checkbox"/> Claudication/Leg Ischemia | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Peripheral Arterial Disease | <input type="checkbox"/> Establish or Evaluate Dialysis Access | <input type="checkbox"/> Non-Healing Wounds |
| <input type="checkbox"/> Renal Artery Stenosis | <input type="checkbox"/> Aortic or Other Aneurysm | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Venous Disease | <input type="checkbox"/> Spine Exposure | |
| <input type="checkbox"/> Abnormal Carotid Ultrasound | <input type="checkbox"/> Mesenteric Ischemia | |

Request for Vascular Studies Vascular Lab Accredited by ACR

**This form is intended to facilitate the care of your patients with vascular needs. If a non-invasive vascular study is all that is required, it will be read by the first available physician to expedite the results.*

Clinical Diagnosis _____

Arterial

- Carotid Ultrasound
- Lower Extremity Arterial Duplex
- Aortic Aneurysm Ultrasound
- Ankle-Brachial Indices (ABI)
- Other _____

Venous/Other

- Upper Extremity
- Lower Extremity
- Dialysis Access Evaluation
- Other _____

When Completed, Please Fax to 866.591.1084